EXHIBIT B

Health Care Requests with responses Dated;
6-4-2020,
6-13-2020,
6-14-2020

MICHIGAN DEPARTMENT OF CORRECTIONS Bureau of Health Care CHJ-549 11/05

HEALTH CARE REQUEST

PRISONER: COMPLETE SECTIONS A THROUGH D

A NAME: Michael Keith George FACILITY: ECF

NUMBER: 827005 LOCK: DATE: 6/4/2020

B. This Health Care Request is for the following (check one or more): ☐ Health Record Copies ☐ Non-urgent

☐ Dental ☐ Medication Refill ☑ Medical ☐ Optometry ☐ Mental Health ☑ Urgent

C. I have the following problems/symptoms: Medication Mental health got me on makes me sick Gives me Pain Put me on Snack Big or take me off the medication i Reported this to Mental health But No help was given Respon on this Request Soon as Possible thank Yal

D NOTICE TO PRISONER

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds".

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged $5.00 for my health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the $5.00 may be taken from my account.

Prisoner Signature: Michael George Date: 6-4-2021

PRISONER: DO NOT WRITE BELOW THIS LINE

E INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on: Date:

Signature: Title: Provider #: Date:

F COPAYMENT (to be filled out by health care):

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

Care that is:

- requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)
- for injuries that are work-related as documented by the prisoner's work supervisor
- requested for testing for HIV, STD's, infestations, or reportable communicable diseases
- requested for evaluation, consultation, or treatment of a mental health need
- prompted by a medical emergency (see Section I of the policy, if self-inflicted)

☐ I have reviewed the visit of _____ (Date) and certify none of these exceptions apply.

Signature: Title: Provider #: Date:

Distribution: White - Health Services, Canary - Prisoner, Pink - Business Office

MICHIGAN DEPARTMENT OF CORRECTIONS – Request for Health Care CHJ-549 11/05

HEALTH CARE REQUEST

PRISONER: COMPLETE SECTIONS A THROUGH D

A NAME: Michael K George FACILITY: ECF

NUMBER: 827005 LOCK: DATE: 6/13/2021

B. This Health Care Request is for the following (check one or more): ☐ Health Record Copies ☐ Non-urgent

☐ Dental ☐ Medication Refill ☑ Medical ☐ Optometry ☑ Mental Health ☑ Urgent

C. I have the following problems/symptoms: the Medication Mental health got Me ON gives Me Red ~~EXY~~ EYES Pain SICK Feeling Makes Me Sleep too MUCH AND Really hot I get UP IN the MORNING With A hard ON EVERY TIME Mental health will NOT help RESPOND Soon AS POSSIBLE thank You

D NOTICE TO PRISONER

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Prisoner Signature: Date:

PRISONER: DO NOT WRITE BELOW THIS LINE

E INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on: Date:

Signature: Title: Provider #: Date:

F COPAYMENT (to be filled out by health care):

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- for injuries that are work-related as documented by the prisoner's work supervisor
- requested for testing for HIV, STD's, infestations, or reportable communicable diseases
- requested for evaluation, consultation, or treatment of a mental health need
- prompted by a medical emergency (see Section I of the policy, if self-inflicted)

☐ I have reviewed the visit of _____ (Date) and certify none of these exceptions apply.

Signature: Title: Provider #: Date:

Distribution: White - Health Services, Canary - Prisoner, Pink - Business Office

MICHIGAN DEPARTMENT OF CORRECTIONS Bureau of Health Care CHJ-549 11/05

HEALTH CARE REQUEST

PRISONER: COMPLETE SECTIONS A THROUGH D

A NAME: Michael Keith GeoRGE FACILITY: ECT

NUMBER: 827005 LOCK: 103 240 DATE: 6-14-21

B. This Health Care Request is for the following (check one or more): ☐ Health Record Copies ☐ Non-urgent

☐ Dental ☐ Medication Refill ☑ Medical ☐ Optometry ☐ Mental Health ☐ Urgent

C. I have the following problems/symptoms: REQUEST SNACK BAG for the Medication MENTAL health got me ON the Medication Makes Me SICK RESPOND SOON thANK YOU

D NOTICE TO PRISONER

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Prisoner Signature: Date:

PRISONER: DO NOT WRITE BELOW THIS LINE

E INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on: Date:

Signature: Title: Provider #: Date:

F COPAYMENT (to be filled out by health care):

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- prompted by a medical emergency (see Section I of the policy, if self-inflicted)

☐ I have reviewed the visit of _____ (Date) and certify none of these exceptions apply.

Signature: Title: Provider #: Date:

Distribution: White - Health Services, Canary - Prisoner, Pink - Business Office

Michigan Department of Corrections
Kite Response

Offender #: 0827005 **Offender Name:** George, Michael Keith

Location: ECF - OAKS CORRECTIONAL FACILITY **Lock:** 03:240L:Bot:B

Discipline:	Medical
Received Date:	06/05/2021
Initiated Date:	06/05/2021
Taken By:	Pant, Zachary [ZP] RN
Request Type:	Other
Request Summary:	medication mental health got me on makes me sick gives me pain. put me on a snack big or take me off the medication i reported this to mental health but no help was given respon on this request as soo as possible
Plan/Action:	a chart review will be sent out